Medical Information Communication Preferences

Patient Name:_____ **DOB:**_____

As our patient we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as lab tests results, to you and/or others involved in your care. Please note that appointment reminder "telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online healthcare information provided by Premier Heart patient secure portal.

Please indicate your communication preferences below:

By listing number(s)/or email(s) below you are giving Premier Heart permission to leave medical information pertaining to you, your dependent, or child.

Method	Yes	No	Area Code, Phone #, Ext, Email
Home Telephone			
Voicemail / Answering machine			
Work phone			
Mobile phone			
Email			

Without specific permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relation to you (i.e. spouse, parent, son, daughter, partner, etc.) below if you would like medical information released to anyone other than yourself. Please check yes if a message with medical information can be left at the number you list below.

Name	**Relationship (i.e. spouse, parent, son daughter, etc.)**	**Area Code, Phone #, extension**	**Yes** to leave a message

Comments:

I assume the responsibility to inform the practice of any changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Patient or Legal Representative: _____ Date: _____

Print Signers Name: _____

PREMIER HEART

HIPAA Notice of Privacy Practices

Acknowledgement Form

By signing below, I acknowledge that I have been provided Premier Heart's Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information. Additionally, I have been given an opportunity to read the Notice.

Signature:_____ Date:_____

Print Name: _____

Signature of Authorized Representative: _____

Office use only:
If unable to obtain the patients signature in acknowledgment of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc)

Patient Name:_____ Date:_____

Reason: _____

PREMIER HEART

Authorization for Release of Information

Patient Name:	**Date of Birth:**

Address:		
City:	**State:**	**Zip Code:**

I authorize the use or disclosure of the above-named individual's health information as described below.

Treatment Dates:

The type of information to be used or disclosed is as follows:

_____ Treatment/ visit notes	_____ EKG	_____ Reports	_____ Medication lists
_____ Lab results	_____ Radiology Reports	_____ Consult notes	_____ Other

This information may be disclosed to and used by the following individual or organization:

Premier Heart, LLC

151 Fries Mills Road, Suite 105

Turnersville, NJ 08012

Office: 856-212-0130 Fax: 856-212-0135

I understand that information in my health record may include information relating to Human Immunodeficiency virus (HIV), AIDS (Acquired Immune Deficiency Syndrome), psychological or psychiatric conditions or treatment, sexually transmitted diseases or drug/alcohol, abuse/ dependence status, detoxification or rehabilitation services.

I understand that I have the right to revoke this authorization at any time. I understand if I revoked this authorization I must do so in writing and present my revocation to Premier Heart. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, this authorization will expire in 1 year.

I understand that authorizing the disclosure of health information is voluntary and I can refuse to sign the form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____